# CMS REGION 10-SEATTLE
# CUSTOMER REFERRAL BRANCH REFERRAL FORM

**Fax to: 206-615-2363** **Telephone: 206-615-2354**

| | |
|---|---|
| **Beneficiary has 0 – 2 days of medications** | |
| **Beneficiary has 3 – 14 days of medications** | |

**INQUIRY SOURCE INFORMATION (If not beneficiary)**

NAME: _____ DATE: _____

ORGANIZATION: _____

TELEPHONE: _____ RELATION TO BENEFICIARY: _____

**BENEFICIARY OR PROVIDER INFORMATION**

NAME: _____ MEDICARE #: _____

TELEPHONE: _____ CELL PHONE: _____

CITY: _____ STATE: _____

**ISSUE TYPE (CHECK ALL THAT APPLY):**

MEDICARE: Part A ☐ Part B ☐ Part C ☐ Part D ☐

IF PART C or D, NOTE PLAN NAME AND #: _____

Language (if other than English): _____

LIS?: YES ☐ NO ☐ SOURCE: SSA ☐ MEDICAID ☐

**ACTIONS TAKEN BY REFERRANT**

☐ Contacted plan but unable to resolve issues

☐ Point of Sale (called 800-662-0210) but unable to process claims

☐ Plan did not accept Best Available Evidence. SSA/Medicaid letter attached

☐ Enrollment Confirmation attached

☐ Termination Letter from Plan attached

**COMMENTS:**

**PHARMACY (CONTACT) INFORMATION (If applicable)**

**PHARMACY:** _____ **CONTACT:** _____

**TELEPHONE:** _____